ADVANCED
Rehab & Sports Medicine Services

PERSONAL LIABILITY / MOTOR VEHICLE SUPPLEMENTAL REGISTRATION FORM

PATIENT INFORMATION	
Name:	Account Number:

Person or persons allegedly responsible for your injuries:

Name:		
Address:		
City:	State:	Zip Code:

Name:		
Address:		
City:	State:	Zip Code:

Are you represented by an attorney in your claims? _____ If Yes, please complete this section

Attorney:					
Law Firm:					
Address:					
City:		State:		Zip Code:	
Phone	( ) -		Facsimile	( ) -	

Is the Alleged Responsible Party represented by an attorney in your claims? _____ If Yes, please complete this section

Attorney:					
Law Firm:					
Address:					
City:		State:		Zip Code:	
Phone	( ) -		Facsimile	( ) -	

In the event your medical claims are to be submitted to a group health plan for injuries sustained in a personal liability / motor vehicle injury <u>you may be responsible for deductibles, co-payments or coinsurance</u>, depending upon the plan design.

X	
Patient / Guardian Signature	Date